Complete Summary

GUIDELINE TITLE

2002 national guideline for the management of genital herpes.

BIBLIOGRAPHIC SOURCE(S)

Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guideline for the management of genital herpes. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [38 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Genital herpes infection (herpes simplex virus type 1 [HSV-1] or 2 [HSV-2] infection)
- Pregnancy

GUIDELINE CATEGORY

Counseling
Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Infectious Diseases
Obstetrics and Gynecology
Urology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To present a national guideline for the management of genital herpes

TARGET POPULATION

- Women, including pregnant women, and men in the United Kingdom with first episode and recurrent genital herpes
- Immunocompromised individuals with genital herpes

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

1. Laboratory detection of herpes simplex virus (HSV) in lesions:
    - Virus culture using swabs/scraping
    - Antigen detection (immunofluorescence on smears)
    - Antigen test using swabs/scraping
    - Nucleic acid test using swabs/scraping
2. Serology:
    - Type specific commercial assays for herpes simplex virus antibodies; either enzyme immunoassays (EIAs) based on glycoprotein G (gG1, GG2) or western blot.

Treatment/Management

1. First episode genital herpes
    - Antiviral drugs: Aciclovir, valaciclovir, or famciclovir (five (5) day regimen)
    - Supportive measures: saline bathing, analgesia, and topical anaesthetic agents
    - Counselling
    - Management of complications, including hospitalisation and catheterisation
2. Recurrent genital herpes
    - Supportive measures: saline bathing, Vaseline, lignocaine gel
    - Episodic antiviral treatment: Oral aciclovir, valaciclovir, or famciclovir (five [5] day regimen)
    - Suppressive antiviral therapy with aciclovir, famciclovir, or valaciclovir
3. Management of herpes in pregnancy
    - Oral or intravenous aciclovir in standard doses
    - Continuous aciclovir in the last four (4) weeks of pregnancy
    - Vaginal delivery
    - Caesarean section
    - Aciclovir treatment of mother and baby
4. Management of herpes in immunocompromised patients
    - Culture

- Increase dose of aciclovir; repeat culture and obtain susceptibility studies
- Topical trifluridine, cidofovir gel, or intravenous foscarnet

MAJOR OUTCOMES CONSIDERED

Recurrrence rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developers searched Medline and the Cochrane Library. The searches focused on the following:

Drug therapy:

- Cochrane search strategy for randomised controlled trials combined with herpes genitalis in Medical Subject Headings (MeSH) and genital herpes (free text).

Diagnosis:

- MeSH "Herpes-genitalis-diagnosis," "Herpes-simplex-diagnosis," "Sensitivity," "Specificity."

Neonatal herpes:

- MeSH "Neonatal herpes," "pregnancy complications-infectious," "Herpes near pregnancy" (free text).

The guideline developers also performed hand searches of reference lists of articles.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence:

Ia

- Evidence obtained from meta-analysis of randomised controlled trials

Ib

- Evidence obtained from at least one randomised controlled trial

IIa

- Evidence obtained from at least one well designed controlled study without randomisation

IIb

- Evidence obtained from at least one other type of well designed quasi-experimental study

III

- Evidence obtained from well designed non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies

IV

- Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The revision process commenced with authors being invited to modify and update their 1999 guidelines. These revised versions were posted on the website for a 3 month period and comments invited. The Clinical Effectiveness Group and the

authors concerned considered all suggestions and agreed on any modifications to be made.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grading of Recommendations:

A (Evidence Levels Ia, Ib)

- Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation.

B (Evidence Levels IIa, IIb, III)

- Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation.

C (Evidence Level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities.
- Indicates absence of directly applicable studies of good quality.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The initial versions of the guidelines were sent for review to the following:

- Clinical Effectiveness Group (CEG) members
- Chairs of UK Regional GU Medicine Audit Committees who had responded to an invitation to comment on them
- Chair of the Genitourinary Nurses Association (GUNA)
- President of the Society of Health Advisers in Sexually Transmitted Diseases (SHASTD)
- Clinical Effectiveness Committee of the Faculty of Family Planning and Reproductive Health Care (FFP)

Comments were relayed to the authors and attempts made to reach a consensus on points of contention with ultimate editorial control resting with the Clinical

Effectiveness Group. Finally, all the guidelines were ratified by the councils of the two parent societies.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence (I-IV) and grades of recommendation (A-C) are defined at the end of the "Major Recommendations" field.

Clinical Features

Symptoms

- Painful ulceration, dysuria, vaginal or urethral discharge
- Systemic symptoms e.g. fever and myalgia
- The patient may be asymptomatic, and the disease unrecognised.
- Rarely, systemic symptoms may be the only evidence of infection.
- Systemic symptoms are much more common in primary than in initial or recurrent disease.

Signs

- Blistering and ulceration of the external genitalia (+/- cervix/rectum)
- Inguinal lymphadenopathy

Complications

- Autonomic neuropathy, resulting in urinary retention
- Aseptic meningitis

Atypical genital herpes

- In the United States, only about 20% of those patients who present to physicians with genital symptoms receive a correct diagnosis of genital herpes

Diagnosis

Virus detection and characterisation

The confirmation and characterisation of the infection and its type, by isolation of herpes simplex virus from genital lesions (see Table 1, below), are essential for diagnosis, prognosis, counselling, and management (Level of Evidence IV, Grade of Recommendation C). Successful diagnosis depends on:

- Using swabs taken directly from the base of the lesion
- Maintaining the cold chain (4 degrees C)
- Rapidly transporting specimens to the laboratory and avoiding freeze-thaw cycles.

Local factors (laboratory resources, distance) will determine the testing strategy.

Table 1. Detection of Herpes Simplex Virus in Lesions, Available Tests

	Virus culture "the gold standard"	Antigen detection (immunofluorescence on smears)	Antigen	Nucleic Acid
Source	Swabs/scraping	Smear/tissue section	Swabs/scraping	Swabs/scraping
Sensitivity	High; >90% from lesions	Low	80%	Highest (used for research studies)
Specificity	High	High	High	Controls for cross-contamination important
Advantages	Allows virus typing and antiviral sensitivity using Monoclonal antibodies	Low cost	Low cost; fast; may be useful late in episode	Allows virus typing, high sensitivity
Disadvantages	Sample transport, labour intensive, expensive	Insensitive	Insensitive, no viral typing	No commercial assay available, expensive

Serology

- Most commercial tests for herpes simplex virus antibodies are not type-specific (for example, complement fixation test [CFT] and many enzyme immunoassays [EIAs]) and are of no value in the management of genital herpes.
- Type specific enzyme immunoassays based on glycoprotein G (gG1, gG2) or western blot are becoming available.
- Tests should be evaluated for sensitivity, specificity and reproducibility using sera from cases confirmed by culture and/or validated established tests before being introduced into clinical practice. Several such validated commercial assays are now available including one near patient test. (Saville et al., 2000; Gopal et al., unpublished)
- Type-specific immune responses can take 8 to 12 weeks to develop following primary infection.

- In the United Kingdom, serological evaluation of genital herpes requires access to both herpes simplex virus-1 and herpes simplex virus-2 type specific antibody assays.
- Caution is needed in interpreting results because even highly sensitive and specific assays have poor predictive values for low prevalence populations (see Table 2 titled "Positive Predictive Values for HSV-2 Antibody Assays" in the original guideline document).
- The clinical utility of these tests has not been fully assessed. Virus detection remains the method of choice. However, they may be helpful in (Munday et al., 1998) (Level of Evidence III, Grade of Recommendation B):
    - Recurrent genital ulceration of unknown cause
    - Counselling patients with initial episodes of disease
    - Investigating asymptomatic partners of patients with genital herpes
    - Evaluation genital herpes during pregnancy
- The value of screening all genitourinary medicine clinic attenders or antenatal patients for herpes simplex virus antibodies has not been established. (Rouse & Stringer, 2000)

Management

First episode genital herpes

General advice

- Saline bathing
- Analgesia
- Topical anesthetic agents (should be used with caution because of potential sensitization)

Antiviral drugs

- Oral antiviral drugs are indicated within 5 days of the start of the episode and while new lesions are still forming.
- Aciclovir, valaciclovir, and famciclovir all reduce the severity and duration of episodes (Level of Evidence Ib, Grade of Recommendation A) (Corey et al., 1983; Fife et al., 1997). Antiviral therapy does not alter the natural history of the disease. (Corey et al., 1985)
- Topical agents are less effective than oral agents.
- Intravenous therapy is only indicated when the patient cannot swallow or tolerate oral medication because of vomiting.
- Combined oral and topical treatment is of no benefit.
- There is no evidence for benefit from courses longer than five days. However, it may be prudent to continue therapy beyond five days if new lesions are still appearing at this time.

Recommended regimens (all for five days):

- Aciclovir 200 mg five times daily
- Famciclovir 250 mg three times daily
- Valaciclovir 500 mg twice daily

Management of complications

- Hospitalisation may be required for urinary retention, meningism, and severe constitutional symptoms.
- If catheterisation is required, suprapubic catheterization is preferred (Level of Evidence IV, Grade of Recommendation C)
    - To prevent theoretical risk of ascending infection
    - To reduce the pain associated with the procedure
    - To allow normal micturition to be restored without multiple removals and recatheterisations

HIV positive patients

Some clinicians advocate a 10-day course of treatment (Level of Evidence IV, Grade of Recommendation C). Lesions unresponsive to therapy may be due to drug resistant herpes simplex virus and drug susceptibility testing of the virus isolate should be considered (see below).

Recurrent genital herpes

- Recurrences are self-limiting and generally cause minor symptoms.
- Management decisions should be made in partnership with the patient.
- Strategies include:
    - Supportive therapy only
    - Episodic antiviral treatments
    - Suppressive antiviral therapy
- The best strategy for managing an individual patient may vary over time according to recurrence frequency, symptom severity, and relationship status.

General advice (Level of Evidence IV, Grade of Recommendation C)

- Saline bathing
- Vaseline
- Lignocaine gel

Episodic antiviral treatment (Level of Evidence Ia, Grade of Recommendation A)

- Oral aciclovir, valaciclovir (Patel et al., 1997), and famciclovir (Mertz et al., 1997) reduce the duration (by median of 1 to 2 days [Nilsen et al., 1982; Spruance et al., 1996; Sacks et al., 1996]) and severity of recurrent genital herpes.
- Patient initiated treatment started early in an episode is most likely to be effective. (Spruance et al., 1996)

Recommended regimens (all for five days):

- Aciclovir 200 mg five times daily
- Valaciclovir 500 mg twice daily
- Famciclovir 125 mg twice daily

Suppressive antiviral therapy

- Patients who have taken part in trials of suppressive therapy have had at least six recurrences per annum. Such patients have fewer or no episodes on suppressive therapy (Level of Evidence Ib, Grade of Recommendation A). Patients with lower rates of recurrence will probably also have fewer recurrences with treatment.
- Patients should be given full information on the advantages and disadvantages of suppressive therapy. The decision to start suppressive therapy is a subjective one, balancing the frequency of recurrence with the cost and inconvenience of treatment.
- Safety and resistance data on patients on long-term therapy with aciclovir (Girard, 1996) now extend to over 13 years of continuous surveillance (Level of Evidence III, Grade of Recommendation B).

  Recommended regimens (Level of Evidence Ib, Grade of Recommendation A)

  - Aciclovir 400 mg twice daily
  - Aciclovir 200 mg four times daily
  - Famciclovir 250 mg twice daily (Mertz et al., 1997)
  - Valaciclovir 250 mg twice daily (250 mg tablets not available in the United Kingdom) (Patel et al., 1997)
  - Valaciclovir 500 mg daily
- Choice of treatment depends on patient compliance and cost (see Table 3 titled "Relative Costs of Antiviral Drugs for Treating Genital Herpes" in the original guideline document).
- Suppressive therapy should be discontinued after a maximum of a year to reassess recurrence frequency. The minimum period of assessment should include two recurrences. Patients who continue to have unacceptably high rates of recurrence may restart treatment. (Level of Evidence IV, Grade of Recommendation C).
- Short courses of suppressive therapy may be helpful for some patients (Level of Evidence IV, Grade of Recommendation C).

Asymptomatic Viral Shedding

- Occurs in individuals with genital herpes simplex virus-1 and those with genital herpes simplex virus-2.
- Occurs most commonly in:
  - Patients with genital herpes simplex virus-2 infection
  - In first year after infection
  - In individuals with frequent symptomatic recurrences
- Is an important cause of transmission
- May be reduced by aciclovir 400 mg twice daily (Level of Evidence Ib, Grade of Recommendation A) (Wald et al., 1996; Koelle et al., 1992)

Counselling

- Diagnosis often causes considerable distress. (Green & Kocsis, 1997) Most people with recurrences adjust over time but antiviral treatment can probably reduce anxiety, assist adjustment and improve quality of life (Patel et al., 1999; Carney et al., 1993) (Level of Evidence II, Grade of Recommendation B).

- Counselling should be as practical as possible and address particular personal situations; issues for someone in a long-term relationship are likely to be different from those for someone seeking a partner.
- Failure by the patient to control everyday stresses does not affect recurrences. (Green & Kocsis, 1997) For most patients one or two counseling sessions with an invitation to return in case of difficulty should be enough.
- Patients who have failed to adjust to the diagnosis after a year should be considered for more intensive counselling interventions.

Counselling should cover:

- Natural history
- The use of antiviral drugs for symptom control; current uncertainties about impact on infectivity should be discussed
- Risks of transmission by sexual and other means, related to the actual situation of the patient
- Patients should be advised to abstain from sexual contact during lesional recurrences or prodromes
- Transmission may occur as a result of asymptomatic viral shedding. Seropositive patients with unrecognised recurrences can be taught to recognise symptomatic episodes after counseling and this may prevent onward transmission (Langenberg et al., 1989)
- Efficacy of condoms to prevent sexual transmission has not been formally assessed
- Pregnancy issues for both men and women (see below)
- Partner notification:
    - Is an effective way of detecting individuals with unrecognised disease (Mertz et al., 1985)
    - May clarify whether a partner is infected or not (utilising type-specific antibody testing if necessary). This may help to relieve anxiety about transmission or reinforce the need to reduce the risk of transmission
    - May help with the counselling process
    - Awareness of the diagnosis in a partner or ex-partner may prevent further onward transmission.

Management of Herpes in Pregnancy

Guidelines for genital herpes in pregnancy are categorized into management of first episodes and recurrent episodes. Accurate clinical classification is difficult. (Hensleigh et al., 1997) Viral isolation and typing and the testing of paired sera (if a booking specimen is available) may be helpful.

First episode genital herpes

First and second trimester acquisition

- Management of the woman should be in line with the clinical condition with the use of either oral or intravenous aciclovir in standard doses (Level of Evidence IV, Grade of Recommendation C).
- Aciclovir is not licensed for use in pregnancy; however, there is substantial clinical experience supporting its safety.

- Vaginal delivery should be anticipated (Level of Evidence IV, Grade of Recommendation C).
- Continuous aciclovir in the last 4 weeks of pregnancy reduces the risk of both clinical recurrence at term delivery by Caesarean section (CS) (Level of Evidence Ib, Grade of Recommendation A) (Scott et al., 1996).

Third trimester acquisition (Level of Evidence IV, Grade of Recommendation C)

- If a true first episode is confirmed (see above) Caesarean section should be considered for all women, particularly those developing symptoms after 34 weeks of gestation, as the risk of viral shedding in labour is very high.
- Caesarean section for the prevention of neonatal herpes has not been evaluated in randomized controlled trials and may not be completely protective against neonatal herpes.
- If vaginal delivery is unavoidable, aciclovir treatment of mother and baby may be indicated.

Recurrent genital herpes (Level of Evidence III, Grade of Recommendation B)

- Sequential cultures during late pregnancy do not predict viral shedding at term. (Prober et al., 1988)
- If there are no genital lesions at delivery, Caesarean section to prevent neonatal herpes should not be performed.
- Symptomatic recurrences during the third trimester are likely to be brief; vaginal delivery is appropriate if no lesions are present at delivery.
- Continuous aciclovir in the last four weeks of pregnancy may modestly reduce the risk of clinical recurrence at term but not of Caesarean section. Aciclovir reduces, but does not eliminate, viral shedding. (Brocklehurst et al., 1998)
- Continuous aciclovir in the last four weeks of pregnancy may be cost-effective compared with no therapy or with Caesarean section. (Randolph, Hartshorn, & Washington, 1996)
- The benefits of obtaining specimens for culture at delivery to identify women who are asymptomatically shedding herpes simplex virus are unproved.

Genital lesions at onset of labour (Level of Evidence III, Grade of Recommendation B)

- Current practice in the United Kingdom is for delivery by Caesarean section, despite lack of evidence for its effectiveness.
- The risks of vaginal delivery for the fetus are small and must be set against risks to the mother of Caesarean section. (Prober et al., 1987)

Prevention of acquisition of infection (Level of Evidence IV, Grade of Recommendation C)

- Maternal risk of herpes simplex virus acquisition in pregnancy varies geographically and local epidemiological surveillance should guide strategy for prevention (Mindel et al., 2000).
- All women should be asked at their first antenatal visit if they or their partner have ever had genital herpes.

- Asymptomatic female partners of men with genital herpes, should be strongly advised not to have sex during recurrences. Conscientious use of condoms throughout pregnancy, especially the third trimester, may diminish the risk of acquisition, but this is unproven.
- Pregnant women should be advised of the risk of acquiring HSV-1 as a result of oro-genital contact.
- Identifying susceptible women by means of type specific antibody testing has not been shown to be cost-effective. (Rouse & Stringer, 2000)
- All women, not just those with a history of genital herpes, should undergo careful vulval inspection at the onset of labour to look for clinical signs of herpes infection.
- Mothers, staff, and other relatives/friends with active oral lesions should be advised about the risk of postnatal transmission.

Management of herpes in immunocompromised individuals

- Clinically refractory lesions due to genital herpes simplex virus are a major problem in patients with severe immunodeficiency, including late stage HIV disease.
- A consensus symposium on management of aciclovir resistant herpes simplex virus led to the publication of guidelines (Balfour et al., 1994), modified in Figure 1 titled "Management of Herpes in Immunocompromised Individuals" in the original guideline document and summarized below:
    1. In immunocompromised patient with active lesions suspected caused by aciclovir resistant herpes simplex virus because failing on standard antiviral therapy or previous aciclovir resistant herpes simplex virus: Obtain culture
    2. If still forming new lesions after 3 to 5 days, increase dosage of aciclovir to 800 mg 5x daily, repeat culture, and arrange susceptibility studies.
    3. Accessible lesions: Topical trifluridine 8 hourly until complete healing or cidofovir gel (0.1% to 0.3%) daily for five days (not available commercially).
    4. Non-accessible lesions: intravenous foscarnet 50mg/kg twice daily until complete healing

Suppressive antiviral therapy

A standard suppressive regimen should be used for immunocompromised patients who have frequently recurring genital herpes.

The relative costs of antivirals are given in Table 3 titled "Relative Costs of Antiviral Drugs for Treating Genital Herpes" in the original guideline document.

Definitions:

Levels of Evidence:

Ia

- Evidence obtained from meta-analysis of randomised controlled trials

Ib

- Evidence obtained from at least one randomised controlled trial

IIa

- Evidence obtained from at least one well designed controlled study without randomisation

IIb

- Evidence obtained from at least one other type of well designed quasi-experimental study

III

- Evidence obtained from well designed non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies

IV

- Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grading of Recommendations:

A (Evidence Levels Ia, Ib)

- Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation.

B (Evidence Levels IIa, IIb, III)

- Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation.

C (Evidence Level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities.
- Indicates absence of directly applicable studies of good quality.

CLINICAL ALGORITHM(S)

An algorithm is provided for the management of herpes in immunocompromised individuals.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is graded and identified for select recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis, prognosis, counselling, and management of genital herpes

POTENTIAL HARMS

Analgesia. Caution should be exercised in using topical anaesthetic agents because of the potential for sensitization.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The Clinical Effectiveness Group reminds the reader that guidelines in themselves are of no use unless they are implemented systematically. The following auditable outcome measures are provided:

- Virological confirmation should be attempted in all patients. Target 100%.
- At least one of the viral isolates should be typed. Target 100%.
- Patients presenting early in the course of first episode genital herpes should be offered antiviral therapy. Target 100%.
- Patients with a diagnosis of genital herpes should be offered counselling, support, and written information. Target 100%.
- Suppressive therapy should be offered to all patients with more than six recurrences annually. Target 100%.
- If suppressive therapy is commenced, a clear plan of duration of treatment should be entered in the notes and the patient should be reviewed in accordance with this. Target 100%.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guideline for the management of genital herpes. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [38 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999 Aug (revised 2002)

GUIDELINE DEVELOPER(S)

Association for Genitourinary Medicine - Medical Specialty Society
Medical Society for the Study of Venereal Diseases - Disease Specific Society

SOURCE(S) OF FUNDING

Not stated

GUIDELINE COMMITTEE

Clinical Effectiveness Group (CEG)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Herpes Simplex Advisory Panel Members (special interest group of the MSSVD): Simon Barton; David Brown; Frances M Cowan; Susan Drake; John Green; George Kinghorn; Patricia E Munday; Raj Patel; Deenan Pillay; Anne Scoular; Derek Timmins; Paul Woolley; Mark Whitaker

Clinical Effectiveness Group (CEG) Members: Keith Radcliffe (Chairman); Imtyaz Ahmed-Jushuf; Jan Welch; Mark FitzGerald; Janet Wilson

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The Herpes Simplex Advisory Panel is a special interest group of the Medical Society for the Study of Venereal Disease (MSSVD). It is currently sponsored by an educational grant from GlaxoWellcome. All panel members have undertaken research and been funded to attend meetings by GlaxoWellcome and/or SmithKline Beecham.

GUIDELINE STATUS

This is the current release of the guideline. This guideline updates a previously released version.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available in HTML format from the Association for Genitourinary Medicine (AGUM) Web site. Also available in Portable Document Format (PDF) from the Medical Society for the Study of Venereal Diseases (MSSVD) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- UK national guidelines on sexually transmitted infections and closely related conditions. Introduction. Sex Transm Infect 1999 Aug;75(Suppl 1):S2-3.

Electronic copies: Available in Portable Document Format (PDF) from the Medical Society for the Study of Venereal Diseases (MSSVD) Web site.

The following is also available:

- Revised UK national guidelines on sexually transmitted infections and closely related conditions 2002. Sex Transm Infect 2002;78:81-2

Print copies: For further information, please contact the journal publisher, BMJ Publishing Group.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on June 15, 2000. The information was verified by the guideline developer on October 13, 2000. This summary was updated on June 24, 2002.

COPYRIGHT STATEMENT

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